		FOR OHF USE					

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2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0036012

Facility Name: Breese Nursing Home

Address: 1155 North First Street (Number) Breese (City) 62230 (Zip Code)

County: Clinton

Telephone Number: (618) 526-4521 **Fax #** (618) 526-2833

IDPA ID Number: 37-1259462001

Date of Initial License for Current Owners: 03/09/1990

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Cindy A. Tefteller **Telephone Number:** (618) 465-7717

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2004 to 12/31/04 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer

(Signed) Accountant's Compilation Report Attached (Date)
(Print Name and Title) Cindy A. Tefteller, Partner
(Firm Name & Address) C. J. Schlosser & Company, 233 East Center Drive, Alton, IL 62002
(Telephone) (618) 465-7717 Fax # (618) 465-7710

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Breese Nursing Home # 0036012 Report Period Beginning: 01/01/2004 Ending: 12/31/04

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	40	Skilled (SNF)	40	14,640	1
2		Skilled Pediatric (SNF/PED)			2
3	72	Intermediate (ICF)	72	26,352	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	112	TOTALS	112	40,992	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	6,085	5,810	2,957	14,852	8
9	SNF/PED					9
10	ICF	10,301	4,071		14,372	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	16,386	9,881	2,957	29,224	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 71.29%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 03/06/1990

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 03/06/1990 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 22 and days of care provided 2,957

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2004 Fiscal Year: 12/31/2004

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Breese Nursing Home # 0036012 Report Period Beginning: 01/01/2004 Ending: 12/31/04

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	176,127	223	5,906	182,256		182,256		182,256			1
2	Food Purchase		124,911		124,911		124,911	(1,401)	123,510			2
3	Housekeeping	69,582	9,092		78,674		78,674		78,674			3
4	Laundry	55,201	8,427		63,628		63,628		63,628			4
5	Heat and Other Utilities			85,685	85,685		85,685		85,685			5
6	Maintenance	49,280	7,951	18,684	75,915		75,915		75,915			6
7	Other (specify):* Sanitation			10,711	10,711		10,711		10,711			7
8	**TOTAL General Services**	350,190	150,604	120,986	621,780		621,780	(1,401)	620,379			8
	B. Health Care and Programs											
9	Medical Director			7,200	7,200		7,200		7,200			9
10	Nursing and Medical Records	1,312,300	59,566	1,785	1,373,651		1,373,651		1,373,651			10
10a	Therapy		1,788	278,024	279,812		279,812		279,812			10a
11	Activities	36,968	1,297	1,200	39,465	379	39,844		39,844			11
12	Social Services	51,555		1,200	52,755		52,755		52,755			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,400,823	62,651	289,409	1,752,883	379	1,753,262		1,753,262			16
	C. General Administration											
17	Administrative	76,354			76,354		76,354		76,354			17
18	Directors Fees											18
19	Professional Services			54,100	54,100		54,100	(746)	53,354			19
20	Dues, Fees, Subscriptions & Promotions			8,158	8,158	(379)	7,779	(285)	7,494			20
21	Clerical & General Office Expenses	107,054	21,150	40,696	168,900		168,900	(1,806)	167,094			21
22	Employee Benefits & Payroll Taxes			310,030	310,030		310,030	(14,962)	295,068			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,602	1,602		1,602		1,602			24
25	Other Admin. Staff Transportation		5,202		5,202		5,202		5,202			25
26	Insurance-Prop.Liab.Malpractice			68,144	68,144		68,144		68,144			26
27	Other (specify):*											27
28	**TOTAL General Administration**	183,408	26,352	482,730	692,490	(379)	692,111	(17,799)	674,312			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,934,421	239,607	893,125	3,067,153		3,067,153	(19,200)	3,047,953			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Breese Nursing Home #0036012 Report Period Beginning: 01/01/2004 Ending: 12/31/04

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			105,924	105,924		105,924	15,781	121,705			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			212,253	212,253		212,253	(7,264)	204,989			32
33	Real Estate Taxes			21,504	21,504		21,504		21,504			33
34	Rent-Facility & Grounds			17,340	17,340		17,340		17,340			34
35	Rent-Equipment & Vehicles			2,100	2,100		2,100		2,100			35
36	Other (specify):* MIP			12,050	12,050		12,050		12,050			36
37	**TOTAL Ownership**			371,171	371,171		371,171	8,517	379,688			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		82,566	18,917	101,483		101,483		101,483			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			61,488	61,488		61,488		61,488			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		82,566	80,405	162,971		162,971		162,971			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,934,421	322,173	1,344,701	3,601,295		3,601,295	(10,683)	3,590,612			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Breese Nursing Home # 0036012 Report Period Beginning: 01/01/2004 Ending: 12/31/04

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,374)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	15,781	30		9
10	Interest and Other Investment Income	(7,264)	32		10
11	Discounts, Allowances, Rebates & Refunds	(27)	2		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,806)	21		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(500)	20		20
21	Owner or Key-Man Insurance	(4,321)	22		21
22	Special Legal Fees & Legal Retainers	(746)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(808)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(9,618)	Var		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (10,683)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (10,683)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Breese Nursing Home

ID# 0036012

Report Period Beginning: 01/01/2004

Ending: 12/31/04

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Entertainment	$ (972)	20	1
2	Civic Dues	(125)	20	2
3	Record 2004 IDPH License Fee Paid in 2003	2,120	20	3
4	Eliminate Owner's Health Insurance	(10,641)	22	4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(9,618)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Breese Nursing Home # 0036012 Report Period Beginning: 01/01/2004 Ending: 12/31/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,401)	0	0	0	0	0	0	0	0	0	0	(1,401)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(1,401)	0	0	0	0	0	0	0	0	0	0	(1,401)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(746)	0	0	0	0	0	0	0	0	0	0	(746)	19
20	Fees, Subscriptions & Promotions	(285)	0	0	0	0	0	0	0	0	0	0	(285)	20
21	Clerical & General Office Expenses	(1,806)	0	0	0	0	0	0	0	0	0	0	(1,806)	21
22	Employee Benefits & Payroll Taxes	(14,962)	0	0	0	0	0	0	0	0	0	0	(14,962)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(17,799)	0	0	0	0	0	0	0	0	0	0	(17,799)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(19,200)	0	0	0	0	0	0	0	0	0	0	(19,200)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Breese Nursing Home # 0036012 **Report Period Beginning:** 01/01/2004 **Ending:** 12/31/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	15,781	0	0	0	0	0	0	0	0	0	0	15,781	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(7,264)	0	0	0	0	0	0	0	0	0	0	(7,264)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	8,517	0	0	0	0	0	0	0	0	0	0	8,517	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(10,683)	0	0	0	0	0	0	0	0	0	0	(10,683)	45

Facility Name & ID Number Breese Nursing Home # 0036012 Report Period Beginning: 01/01/2004 Ending: 12/31/04

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Mark E. Halloran	50.00%					
Garrett C. Reuter	50.00%					

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [X] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Breese Nursing Home # 0036012 Report Period Beginning: 01/01/2004 Ending: 12/31/04

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	Mark E. Halloran	President		0.50	None	12	30.00	Salary	$ 12,066	17,1	1
2	Garrett C. Reuter		Counsel	0.50	None	12	30.00	Salary	12,066	17,1	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 24,132		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Breese Nursing Home # 0036012 Report Period Beginning: 01/01/2004 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Breese Nursing Home # 0036012 Report Period Beginning: 01/01/2004 Ending: 12/31/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Gershman Investment Group		X	Refinance Mortgage	$17,832.17	3/16/2000	$ 2,478,900	$ 2,406,298	3/16/2035	8.1250	$ 196,180	1
2												2
3								Amortization of Loan Costs			3,257	3
4												4
5												5
	Working Capital											
6	Mark Halloran & Garrett											6
7	Reuter	X		Working Capital		12/31/02	137,531	200,534		7.0000	12,816	7
8												8
9	TOTAL Facility Related				$17,832.17		$ 2,616,431	$ 2,606,832			$ 212,253	9
	B. Non-Facility Related*											
10												10
11												11
12								Interest Income			(7,264)	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (7,264)	14
15	TOTALS (line 9+line14)						$ 2,616,431	$ 2,606,832			$ 204,989	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 12,050 Line # 36

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Breese Nursing Home # 0036012 Report Period Beginning: 01/01/2004 Ending: 12/31/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2003 report.	*Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 25,200	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 22,904	2
3. Under or (over) accrual (line 2 minus line 1).		$ (2,296)	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 23,800	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 21,504	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1999	23,703	8
	2000	24,640	9
	2001	24,416	10
	2002	24,198	11
	2003	22,904	12

The payment on line 2 was for the 2003 tax year.

The accrual used on line 4 was based on the 2003 tax paid.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Breese Nursing Home COUNTY Clinton

FACILITY IDPH LICENSE NUMBER 0036012

CONTACT PERSON REGARDING THIS REPORT Mark Halloran, President

TELEPHONE (6168) 632-2500 FAX #: (618) 622-0800

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	06-06-22-252-008	Sec 22 Twp 2 Rng 4 Pt W 1/2 NE	$ 22,904.38	$ 22,904.38
2.		NE 4A	$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 22,904.38	$ 22,904.38

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

Facility Name & ID Number Breese Nursing Home # 0036012 Report Period Beginning: 01/01/2004 Ending: 12/31/04

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 30,286 B. General Construction Type: Exterior Masonry Frame Reinforced Concrete Number of Stories 1

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: N/A
2. Number of Years Over Which it is Being Amortized: N/A
3. Current Period Amortization: N/A
4. Dates Incurred: N/A

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	174,242	1990	$ 15,400	1
2					2
3	TOTALS	174,242		$ 15,400	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Breese Nursing Home # 0036012 Report Period Beginning: 01/01/2004 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	112		1990	1975	$ 1,750,695	$ 55,578	31.5	$ 55,578	$	$ 822,083	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Beg Balance			1975	10,000	318	31.5	318		4,695	9
10	Roof			1990	101,563	3,224	31.5	3,224		46,376	10
11	Air Conditioner			1990	2,828	90	31.5	90		1,307	11
12	Interior Renovation			1990	1,803	41	7-31.5	41		1,087	12
13	Air Conditioner Pad			1990	2,645	156	15	176	20	2,600	13
14	Roof			1991	48,265	1,532	31.5	1,532		21,003	14
15	Handrails			1991	4,884	155	31.5	155		2,099	15
16	Soffits & Siding			1991	11,204	356	31.5	356		4,872	16
17	Carpet			1991	1,987		7			1,987	17
18	Air Conditioner			1991	4,755	151	31.5	151		2,032	18
19	HVAC - Dining Room			1991	5,510	175	31.5	175		2,143	19
20	Cubicle Tracking			1992	1,815		7			1,815	20
21	Plastering			1992	1,952	62	31.5	62		728	21
22	Cubicle Tracking			1993	657		20	33	33	386	22
23	Carpet & Tile			1993	1,481		5			1,481	23
24	Air Conditioning			1993	5,877	151	10		(151)	5,877	24
25	Fire Alarm			1993	10,700	274	15	713	439	8,024	25
26	Front Door			1994	1,368	35	10	114	79	1,368	26
27	Electrical Wiring			1994	9,131	234	20	457	223	4,795	27
28	Back Patio			1994	5,137	303	10	171	(132)	5,137	28
29	Landscaping			1994	1,221	72	10	51	(21)	1,221	29
30	Front Parking Lot			1994	80,603	4,760	10	6,046	1,286	80,603	30
31	Lighting & Ceiling			1994	2,110		10	159	159	2,110	31
32	Gutters & Shutters			1994	2,111	54	27	78	24	801	32
33	Dining Room Improvements			1994	2,558	66	27	95	29	956	33
34	Plumbing			1994	4,528	116	20	227	111	2,452	34
35	Ceiling Tile			1994	614	16	12	51	35	528	35
36	Laundry Improvements			1994	1,162	30	27	43	13	466	36

*Total beds on this schedule must agree with page 2.

See Page 12A, Line 70 for total

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Breese Nursing Home # 0036012 Report Period Beginning: 01/01/2004 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	AdminstrativeOffice Improvements	1994	$ 1,048	$ 27	15	$ 70	$ 43	$ 751	37
38	Water Softener	1994	3,661	94	12	305	211	3,305	38
39	Air Conditioners	1994	31,460	807	10	1,832	1,025	31,460	39
40	Window Blinds	1995	6,010		20	301	301	2,730	40
41	Land Improvements	1995	1,224	72	10	122	50	1,120	41
42	Sign	1995	2,455		12	205	205	1,996	42
43	Parking Lot Lighting	1995	7,456		15	497	497	4,846	43
44	Flag Pole	1995	1,511	89	20	76	(13)	730	44
45	Landscaping	1995	2,206	130	10	221	91	2,097	45
46	Landscaping	1996	2,927		10	293	293	2,489	46
47	Kitchen Renovations	1996	13,339		25	534	534	4,537	47
48	Window Screens	1996	914		5			914	48
49	Remodel Nurse Station	1996	1,077		25	43	43	366	49
50	Reception Room Addition	1996	3,721		25	149	149	1,265	50
51	Doors - Alzheimer Unit	1996	1,030		25	41	41	350	51
52	Shrubs	1997	1,001	59	15	67	8	501	52
53	Fence	1997	1,141	67	15	76	9	596	53
54	Fixtures	1997	2,835	126	10	284	158	2,149	54
55	Windows	2000	35,000	897	10	3,500	2,603	17,500	55
56	Light Fixtures	2000	1,500	38	10	150	112	750	56
57	Sink Fixtures	2000	7,350	188	20	368	180	1,838	57
58	10 Ton HVAC	2000	10,000	256	17	588	332	2,940	58
59	Water Softener	2000	40,000	1,026	12	3,333	2,307	16,666	59
60	Water Heater	2000	1,500	39	15	100	61	500	60
61	Air Handling Unit	2000	3,000	77	15	200	123	1,000	61
62	Rear Parking Lot	2000	44,000	3,047	15	2,933	(114)	14,666	62
63	Dumpster Pad	2000	900	62	15	60	(2)	300	63
64	Shower Room Remodel	2001	15,000	385	15	1,000	615	4,000	64
65	Grab Bars	2002	4,800	123	15	320	197	960	65
66	Tuck Point	2002	1,000	26	15	67	41	201	66
67	Regrout	2002	1,500	39	15	100	61	300	67
68	Air Handler	2002	3,000	77	15	200	123	600	68
69	Remodel Sprayout Room	2002	2,481	64	15	165	101	613	69
70	TOTAL (lines 4 thru 69)		$ 2,335,211	$ 75,764		$ 88,296	$ 12,532	$ 1,156,068	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Breese Nursing Home # 0036012 Report Period Beginning: 01/01/2004 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 2,335,211	$ 75,764		$ 88,296	$ 12,532	$ 1,156,068	1
2	Drainage	2002	1,500	90	15	100	10	300	2
3	Roof	2003	3,697	117	10	370	253	493	3
4	Floor Tile	2004	47,390	50	10		(50)		4
5	Door Alarm	2004	6,074	123	10	506	383	506	5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,393,872	$ 76,144		$ 89,272	$ 13,128	$ 1,157,367	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Breese Nursing Home # 0036012 Report Period Beginning: 01/01/2004 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 274,048	$ 17,318	$ 28,981	$ 11,663	5-15 Yrs	$ 179,288	71
72	Current Year Purchases	23,236	9,295	715	(8,580)	5-20 Yrs	715	72
73	Fully Depreciated Assets	496,131					496,131	73
74								74
75	TOTALS	$ 793,415	$ 26,613	$ 29,696	$ 3,083		$ 676,134	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility Business	1991 Van	1991	$ 21,781	$	$	$	5	$ 21,781	76
77	Facility Business	Wheelchair Lift	1996	4,345		362	362	12	3,259	77
78	Facility Business	1993 Ford E150	2003	9,500	3,167	2,375	(792)	4	3,365	78
79										79
80	TOTALS			$ 35,626	$ 3,167	$ 2,737	$ (430)		$ 28,405	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 3,238,313	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 105,924	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 121,705	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 15,781	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,861,906	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Section Not Applicable	$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92	Section Not Applicable	$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Section Not Applicable

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [ ] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: [ ] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	$
13.	/2006	$
14.	/2007	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [N/A] YES [N/A] NO

16. Rental Amount for movable equipment: $ 2,100 Description: Dishwasher
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Section Not Applicable		$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Breese Nursing Home # 0036012 Report Period Beginning: 01/01/2004 Ending: 12/31/04

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Breese Nursing Home # 0036012 Report Period Beginning: 01/01/2004 Ending: 12/31/04

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4		5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a, 3	hrs	$	3,873	$	121,913	$	3,873	$ 121,913	1
2	Licensed Speech and Language Development Therapist	10a, 3	hrs		1,199		58,528		1,199	58,528	2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist	10a, 2 & 3	hrs		3,072		97,583		3,072	97,583	4
5	Physician Care		visits								5
6	Dental Care		visits								6
7	Work Related Program		hrs								7
8	Habilitation		hrs								8
9	Pharmacy	39, 2	# of prescrpts					82,566		82,566	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10
11	Academic Education		hrs								11
12	Exceptional Care Program										12
13	Other (specify): Amb., X-Ray & Lab	39, 3					18,917			18,917	13
14	TOTAL			$	8,144	$	296,941	$ 82,566	8,144	$ 379,507	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Breese Nursing Home # 0036012 Report Period Beginning: 01/01/2004 Ending: 12/31/04

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/04 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 510,666	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	481,174		3
4	Supply Inventory (priced at)	17,500		4
5	Short-Term Investments			5
6	Prepaid Insurance	7,598		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,016,938	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	15,400		13
14	Buildings, at Historical Cost	2,381,424		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	826,133		16
17	Accumulated Depreciation (book methods)	(1,839,998)		17
18	Deferred Charges	98,265		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,481,224	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,498,162	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 199,979	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	80,110		30
31	Accrued Taxes Payable (excluding real estate taxes)	6,110		31
32	Accrued Real Estate Taxes(Sch.IX-B)	23,800		32
33	Accrued Interest Payable	16,292		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Due to Shareholders	200,534		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 526,825	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	2,406,298		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 2,406,298	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,933,123	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (434,961)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,498,162	$	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Breese Nursing Home # 0036012 Report Period Beginning: 01/01/2004 Ending: 12/31/04

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (384,961)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (384,961)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	21,500	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(71,500)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (50,000)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (434,961)	24 *

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Breese Nursing Home # 0036012 Report Period Beginning: 01/01/2004 Ending: 12/31/04

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,654,002	1
2	Discounts and Allowances for all Levels	(687,633)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,966,369	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	583,045	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 583,045	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	1,374	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	35,443	19
20	Radiology and X-Ray	17,128	20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 53,945	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	7,264	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 7,264	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Micellaneous Revenue	12,172	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 12,172	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,622,795	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	621,780	31
32	Health Care	1,752,883	32
33	General Administration	692,490	33
	B. Capital Expense		
34	Ownership	371,171	34
	C. Ancillary Expense		
35	Special Cost Centers	101,483	35
36	Provider Participation Fee	61,488	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,601,295	40
41	**Income before Income Taxes (line 30 minus line 40)****	21,500	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 21,500	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** Not yet filed **If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.** SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Breese Nursing Home # 0036012 Report Period Beginning: 01/01/2004 Ending: 12/31/04

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,864	2,019	$ 48,165	$ 23.86	1
2	Assistant Director of Nursing					2
3	Registered Nurses	11,651	12,486	252,080	20.19	3
4	Licensed Practical Nurses	19,839	20,954	367,183	17.52	4
5	Nurse Aides & Orderlies	55,026	58,516	621,676	10.62	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	3,954	4,119	36,968	8.97	10
11	Social Service Workers	2,149	2,567	51,555	20.08	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	16,737	17,806	176,127	9.89	15
16	Dishwashers					16
17	Maintenance Workers	2,890	3,133	49,280	15.73	17
18	Housekeepers	8,561	8,919	69,582	7.80	18
19	Laundry	7,029	7,452	55,201	7.41	19
20	Administrator	1,861	2,016	52,222	25.90	20
21	Assistant Administrator					21
22	Other Administrative	1,200	1,200	24,132	20.11	22
23	Office Manager					23
24	Clerical	8,061	8,371	107,054	12.79	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,012	2,042	23,196	11.36	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	142,834	151,600	$ 1,934,421 *	$ 12.76	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	160	$ 5,707	1,3	35
36	Medical Director	Contract	7,200	9,3	36
37	Medical Records Consultant	12	465	10,3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Contract	1,320	10,3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Contract	1,200	11,3	44
45	Social Service Consultant	Contract	1,200	12,3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	172	$ 17,092		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$ Section N/A		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

Facility Name & ID Number Breese Nursing Home # 0036012 Report Period Beginning: 01/01/2004 Ending: 12/31/04

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Mark Halloran	Owner	50.00%	$ 12,066
Garrett Reuter	Owner	50.00%	12,066
Joseph Hussman	Administrator	0.00%	52,222
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 76,354

B. Administrative - Other

Description	Amount
Section Not Applicable	$
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$

C. Professional Services

Vendor/Payee	Type	Amount
C. J. Schlosser & Co.	Accounting	$ 30,700
Wenzel & Associates	Accounting	4,647
Greensfelder, Hemker, & Gale	Legal	6,966
Griffin, Winning, Cohen, & Bodewes	Legal	1,863
Paychex, Inc.	Accounting	9,924
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 54,100

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 126,922
Unemployment Compensation Insurance	17,679
FICA Taxes	145,703
Employee Health Insurance	
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Appreciation	2,200
Employee Exams	275
Tuition Reimbursement	438
401(k) Fees	1,851
TOTAL (agree to Schedule V, line 22, col.8)	$ 295,068

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
Section Not Applicable		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 2,120
Advertising: Employee Recruitment	3,041
Health Care Worker Background Check (Indicate # of checks performed 35)	500
Promotional Advertising	808
Subscriptions	1,011
Miscellaneous Expenses	822
Less: Public Relations Expense	( )
Non-allowable advertising	(808)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 7,494

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,602
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,602

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Breese Nursing Home # 0036012 Report Period Beginning: 01/01/2004 Ending: 12/31/04

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1	Section Not Applicable		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Breese Nursing Home # 0036012 **Report Period Beginning:** 01/01/2004 **Ending:** 12/31/04

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount. **N/A**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 Yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **None** Line **N/A**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **61,488**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **None**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **N/A** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **1,374**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **None**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **C. J. Schlosser & Company, L.L.C.** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **No** If no, please explain. **Audit Not Complete**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.

CARING FIRST, INC. D/B/A BREESE NURSING HOME
ATTACHMENT TO SCHEDULE V, LINE 25
12/31/2004

OTHER ADMIN. STAFF TRANSPORTATION:	
MILEAGE REIMBURSEMENT	$ 5,202
	$ 5,202

** ALL MILEAGE REIMBURSEMENTS ARE FOR TRAVEL VOUCHERS SUBMITTTED WHICH WERE LESS THAN $250.00 EACH.

Caring First, Inc. d/b/a Breese Nursing Home
Attachment to Schedule XVII, Line 28
12/31/2004

Lawsuit Settlement	$	9,092
Flu Vaccines		2,941
Medical Records Copies		62
Food Refund		27
Miscellaneous		50
	$	12,172

CARING FIRST INC. D/B/A BREESE NURSING HOME
RECLASSIFICATIONS
MEDICAID COST REPORT
12/31/2004

	AMOUNT	LN #
A		
ACTIVITIES	379	11
DUES, SUBSCRIPTIONS & PROMOTIONS	(379)	20
TO RECLASS RESIDENT PARTIES		